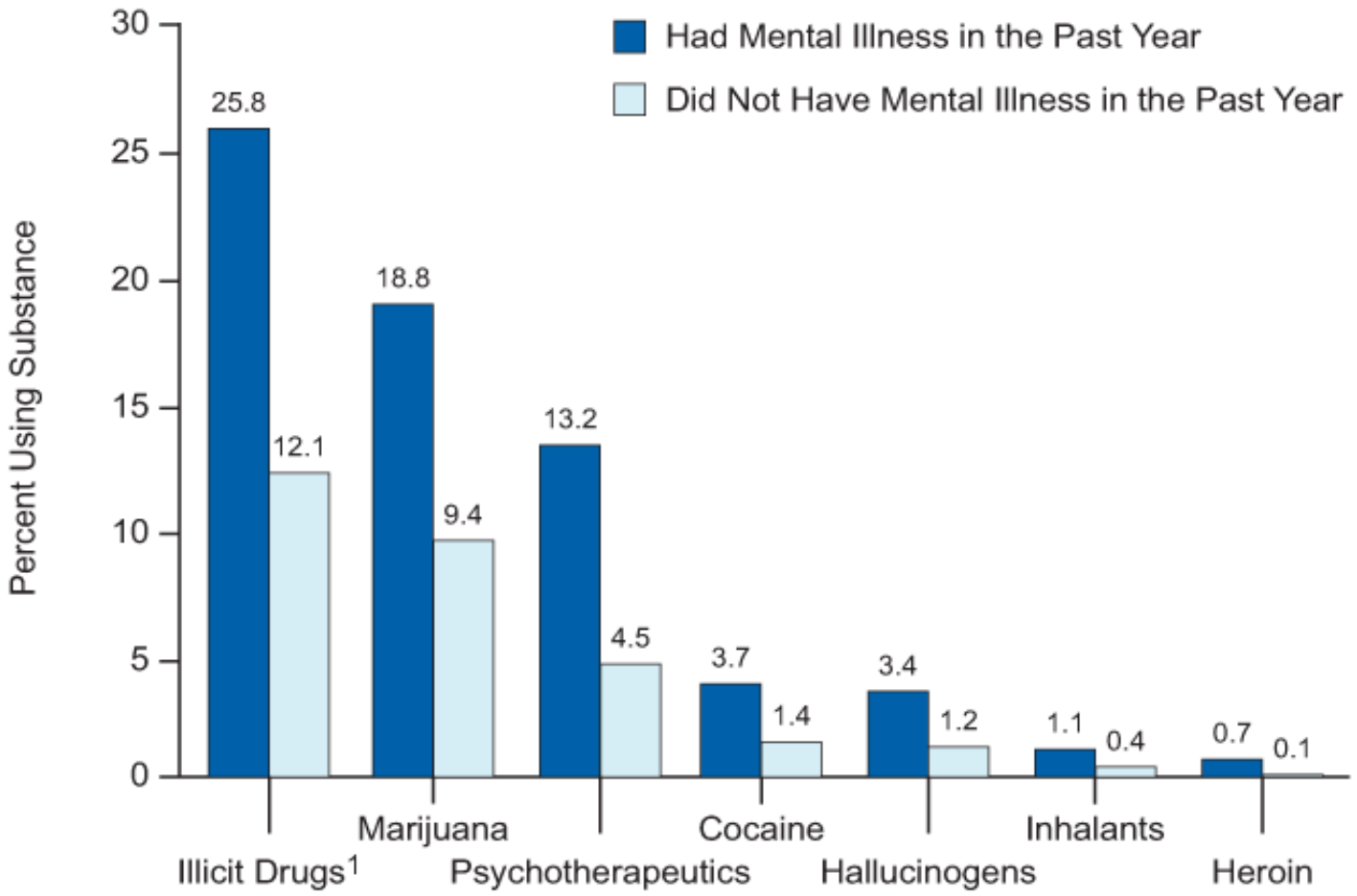
# Integrating Mental Health and Addiction into Primary Care

1. Identify ways to reduce prescription drug addiction by first assessing one's risk of substance abuse through screening
2. Evaluate how the integration of mental health and addiction into primary care can be used to decrease prescription drug abuse
3. Discuss the impact of intervention on provider, patient and administrative outcomes

# Why Screen Patients for Substance Use and Mental Illness?

- Mental illness is common among patients with risky substance use
- Use more than 1 substance is common among substance users
- Mental illness and substance use increases risk of aberrant opioid use
- Screening is cost-effective

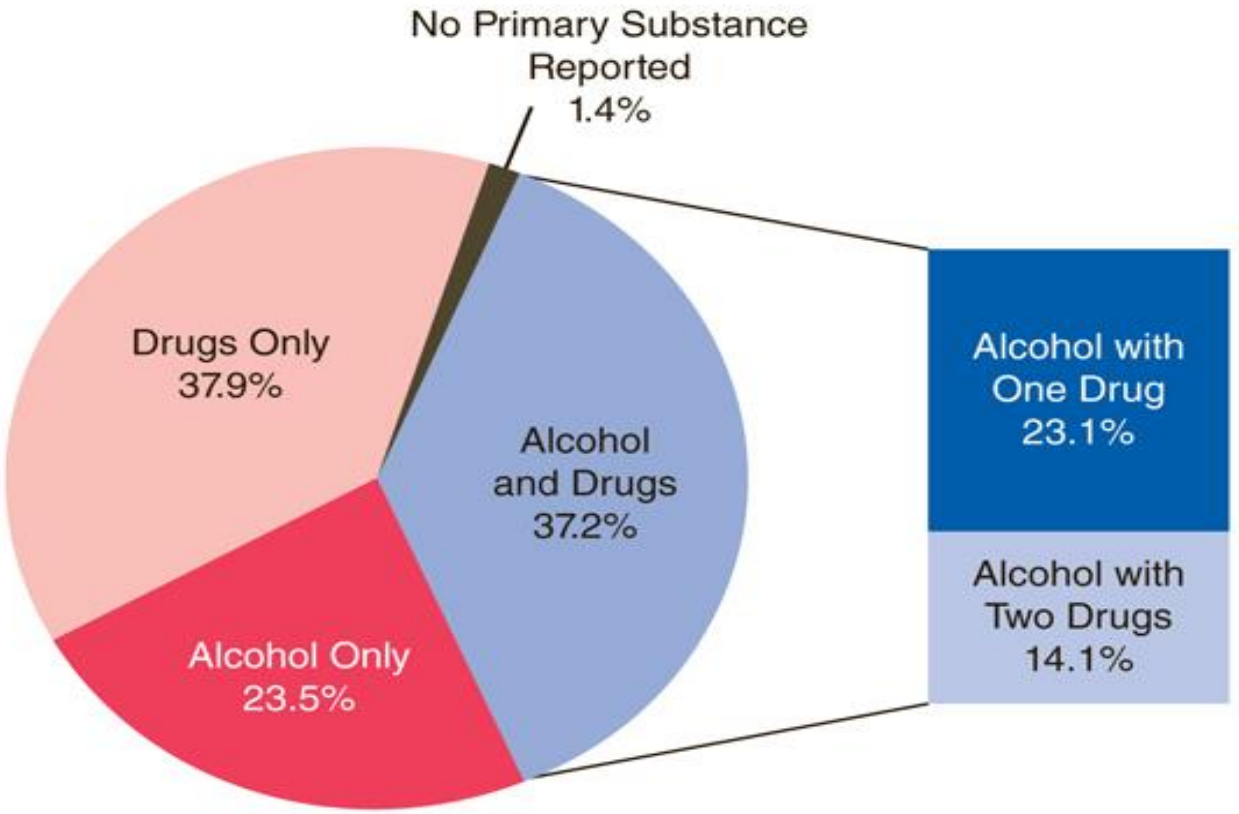
# Mental Illness & Substance Use




Past Year Substance Use Among Adults Aged 18 or Older, by Any Mental Illness

SAMHSA: National Survey on Drug Use and Health, 2010

# Patterns Among Patients Admitted to Substance Use Treatment




SAMHSA: Treatment Episode Data Set, 2009

# Risk Factors for Opioid-Related Aberrant Behavior

**Table 5** Risk factors for opioid-related aberrant behavior (items composing the Opioid Risk Tool)

| Risk Factor | Females (N = 108) n (%) | Males (N = 77) n (%) | *P* Value* |
|---|---|---|---|
| Family history of substance abuse | | | |
| Alcohol | 54 (50) | 53 (69) | 0.011 |
| Illegal drugs | 21 (19) | 12 (16) | 0.499 |
| Other (prescription drugs) | 10 (9) | 2 (3) | 0.070 |
| Personal history of substance abuse | | | |
| Alcohol | 17 (16) | 22 (29) | 0.035 |
| Illegal drugs | 14 (13) | 13 (17) | 0.457 |
| Prescription drugs | 23 (21) | 12 (16) | 0.328 |
| Age ≤45 | 62 (57) | 43 (56) | 0.832 |
| History of preadolescent sexual abuse | 43 (40) | 6 (8) | <0.001 |
| Psychological disease | | | |
| Attention deficit disorder, obsessive-compulsive disorder, bipolar, or schizophrenia | 28 (26) | 13 (17) | 0.144 |
| Depression | 77 (71) | 44 (57) | 0.046 |

* Chi-square test.

Pain Med. 2005 Nov-Dec;6(6):432-42.

# Screening Expectations vs. Reality

- Primary care providers infrequently screen for substance use
  - Lack of time
  - Lack of comfort discussing substance use
  - Lack of expertise in treating substance use
  - Lack of referral mechanisms for identified disorders
- Patients expect primary care providers to ask
- Most patients entering treatment for SU self-refer

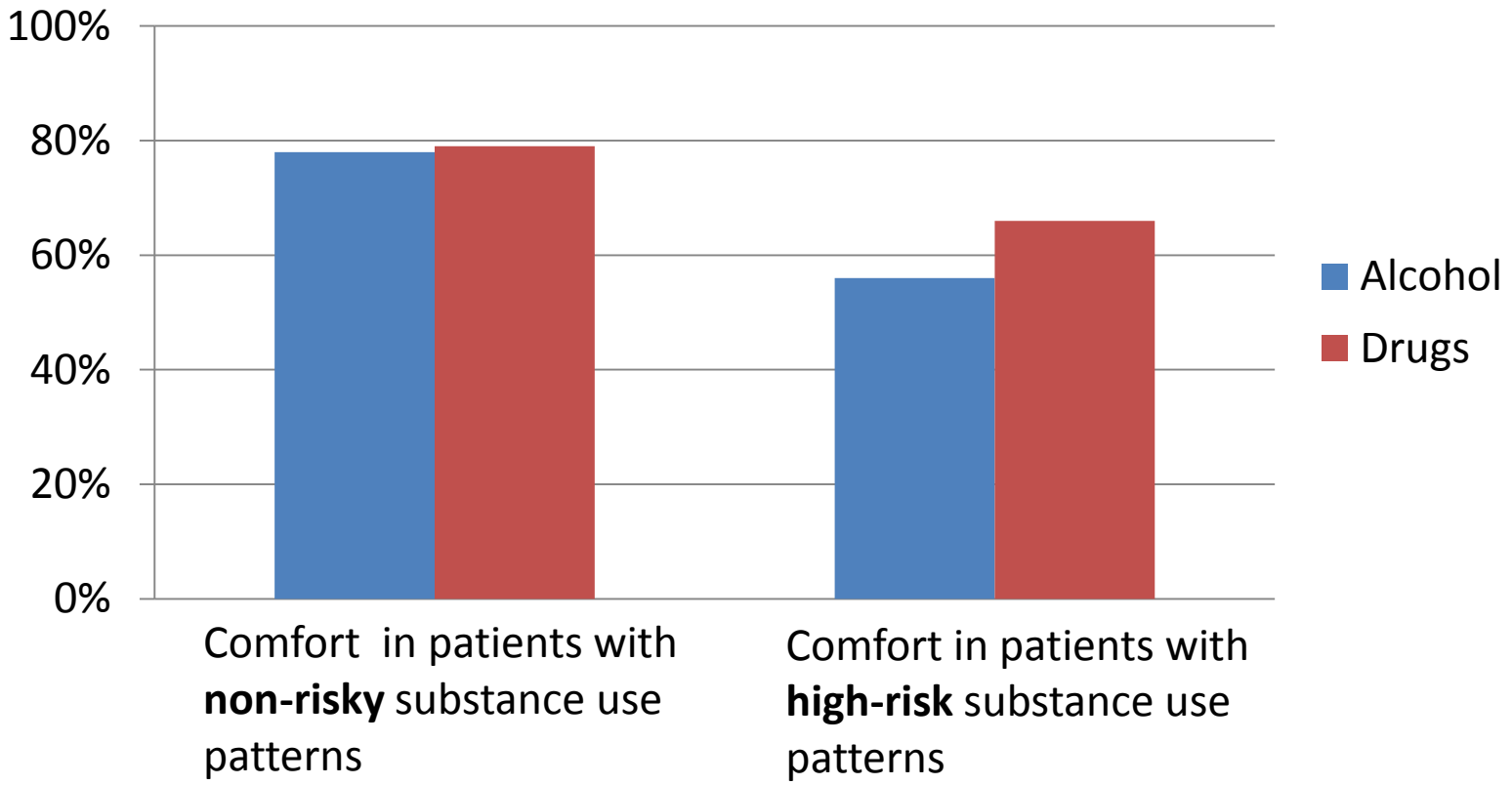
# Deficiencies in Alcohol Use Screening in Primary Care: we are not asking

**TABLE 1. Weighted prevalence of discussing alcohol use with a doctor or other health professional among U.S. adults, by sociodemographic characteristics — Behavioral Risk Factor Surveillance System, 44 states and**

| Characteristic | Unweighted No. | Talked with about alcohol use | | | |
|---|---|---|---|---|---|
| | | Ever | | During past year | |
| | | % | (95% CI) | % | (95% CI) |
| **Total** | **166,753** | **15.7** | **(15.0–16.4)** | **7.6** | **(6.9–8.2)** |
| **Sex** | | | | | |
| Men | 64,836 | 19.0 | (17.9–20.3) | 9.2 | (8.0–10.5) |
| Women | 101,917 | 12.5 | (12.0–13.1) | 6.0 | (5.7–6.4) |
| **Age (yrs)** | | | | | |
| 18–24 | 6,529 | 27.9 | (24.2–32.1) | 15.9 | (12.0–20.6) |
| 25–34 | 15,411 | 17.1 | (16.0–18.1) | 7.8 | (7.1–8.6) |
| 35–44 | 21,333 | 14.6 | (13.7–15.5) | 6.5 | (6.0–7.2) |
| 45–64 | 68,414 | 14.6 | (13.9–15.2) | 6.7 | (6.3–7.1) |
| ≥65 | 53,525 | 9.3 | (8.8–9.8) | 4.2 | (3.9–4.6) |

CDC. Vital Signs, 2011. MMWR 2014; 63(01);16-22

# Patient Comfort with Substance Use Discussions with Their PCP




Fam Med. 2013 February ; 45(2): 109–117

# SBIRT: A New Approach

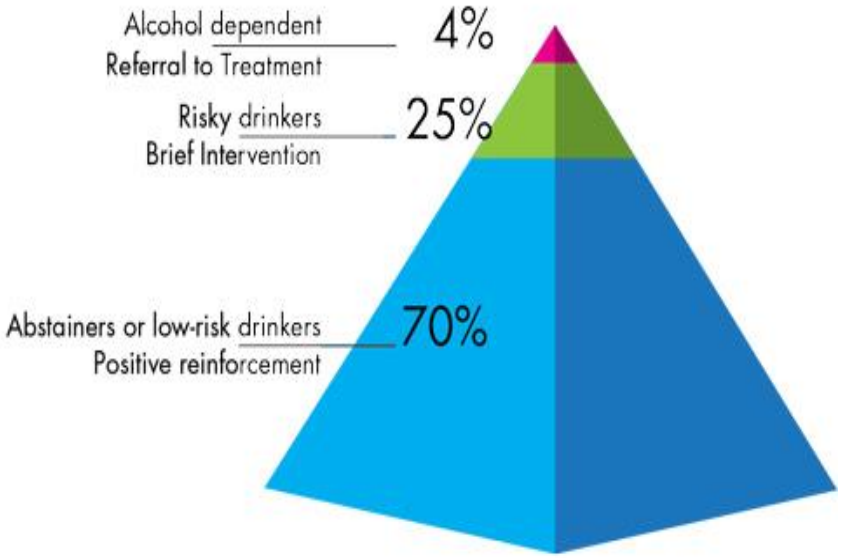
- **S**creening
- **B**rief **I**ntervention
- **R**eferral to **T**reatment

# Evolution of SBIRT

- Brief interventions (BI)
  - Identify real or potential SU problem
  - Motivate patient to change behavior
- Evidence for BI
  - 4 meta-analyses to date
  - Includes BI in PC settings
  - Effectiveness shown in multiple areas
    - Smoking
    - Obesity
    - Medication compliance in hyperlipidemia & hypertension
    - Risky alcohol use
- In late 1990s, SAMHSA endorsed SBIRT as public health intervention

# SAMHSA's Version of SBIRT

- Brief
- Universal screening
- Targeted behaviors
- Non-SU treatment setting
- Comprehensive
- Evidence-based




Source: Substance Abuse and Mental Health Services Administration. (2006) Results from the 2005 National Survey on Drug Use and Health:National findings Rockville (MD): Office of Applied Studies

# Cost-effectiveness of Screening

| Ranking | Preventive Service |
|---|---|
| 1 | Daily aspirin use |
| 2 | Childhood immunizations |
| 3 | Smoking cessation |
| 4 | Alcohol screening & brief counseling |
| 5 | Colorectal cancer screening |
| 6 | Hypertension screening & treatment |
| 9 | Cervical cancer screening |
| 10 | Cholesterol screening & treatment |
| 12 | Breast cancer screening |
| 18 | Depression screening |

Am J Prev Med 2006; 31(1):52-61.

# How we got involved


# How we got started at IU

- Call for proposals (SAMHSA) to train medical residents (medicine, pediatrics, family medicine, OB, emergency medicine) in screening and brief intervention (brought to us by the Indiana Prevention Research Center)
- Confluence of interests between Department of Medicine, IPRC, Midtown Community Mental Health, and Wishard/Eskenazi Health

# The process

- Gathering of stakeholders, including those with authority to make changes (residency program directors, clinic managers and supervising physicians)
- Regular meetings (every 2 weeks x 5 years!)
- Created web modules (available to you: http://iusbirt.org/) and face-to-face training
- Regular review and revision of procedures

# Goal: make SBIRT second nature, like recording vital signs

- Lessons learned from IUSM SBIRT
  - Overcome (roll with?) resistance of the residents to participate (time demands, personal attributes)
  - Build SBIRT into the clinic work flow
  - Transfer the screening to clinic staff
  - Figure out the medical informatics angles (recording and following up on results): this may have been the hardest issue
  - Big need: integration of behavioral health

# Why Integrate?

- High percentage of depression identified and treated and in primary care settings
- Comorbid medical diagnosis- are common with depression, anxiety and substance abuse
- Earlier identification and treatment of mental health and substance use disorders

- If we can't offer the next step for positive screens, there is less incentive to screen

# Why Integrate?

- Immediate handoff from SBIRT staff to mental health staff
- Provide immediate education on substance use with engagement of client
- Poor follow up with referral to off site specialty substance use treatment
- Opportunity to educate medical providers about substance use

# Indiana SBIRT

- SAMHSA 5 year grant awarded to Indiana in 2011
- Partnership with state, IPRC, Wishard/Eskenazi, Midtown
- Integrated into all of the FQHC's over a 5 year period
  - Screen all adults 18 and above annually
  - Ask 4 pre-screening questions (followed by more detailed questions if positive)
    - 1 alcohol question (binging)
    - 1 drug
    - 2 depression

# Indiana SBIRT

- Training with all of the staff in the clinic
  - Tailored to discipline and approached as an improvement to patient care
    - Medical assistants, nurses, site manager, physicians, NP, PA, auxiliary staff
  - 11 different approaches unique to each clinic
  - Clinic champion important for overall success
  - If at first you don't succeed……
  - Computer based training and in person training
  - Lots of communication

# Indiana SBIRT: the outcomes

| Category | Number | Percentage of Total Prescreens | Percentage of Total Positive |
|---|---|---|---|
| Patients Prescreened | 48340 | n/a | n/a |
| Positive **Alcohol** Prescreens | 4463 | 9.23% | n/a |
| Positive **Drug** Prescreens | 2217 | 4.59% | n/a |
| Positive **Depression** Prescreens | 9352 | 19.35% | n/a |
| Positive **AOD** Prescreens (*total, non-repeating* ) | 5722 | 11.84% | n/a |
| Positive **Depression** Only | 7270 | 15.04% | n/a |
| Total Positive | 12992 | 26.88% | n/a |
| Treatment Modalities Used (for positive AOD prescreens) | | | |
| None | 1640 | 3.39% | 28.66% |
| Brief Intervention | 1552 | 3.21% | 27.12% |
| Brief Treatment | 587 | 1.21% | 10.26% |
| Referral to Treatment | 396 | 0.82% | 6.92% |
| Delayed Until Next Visit | 1540 | 3.19% | 26.91% |

# Lessons Learned-Integration

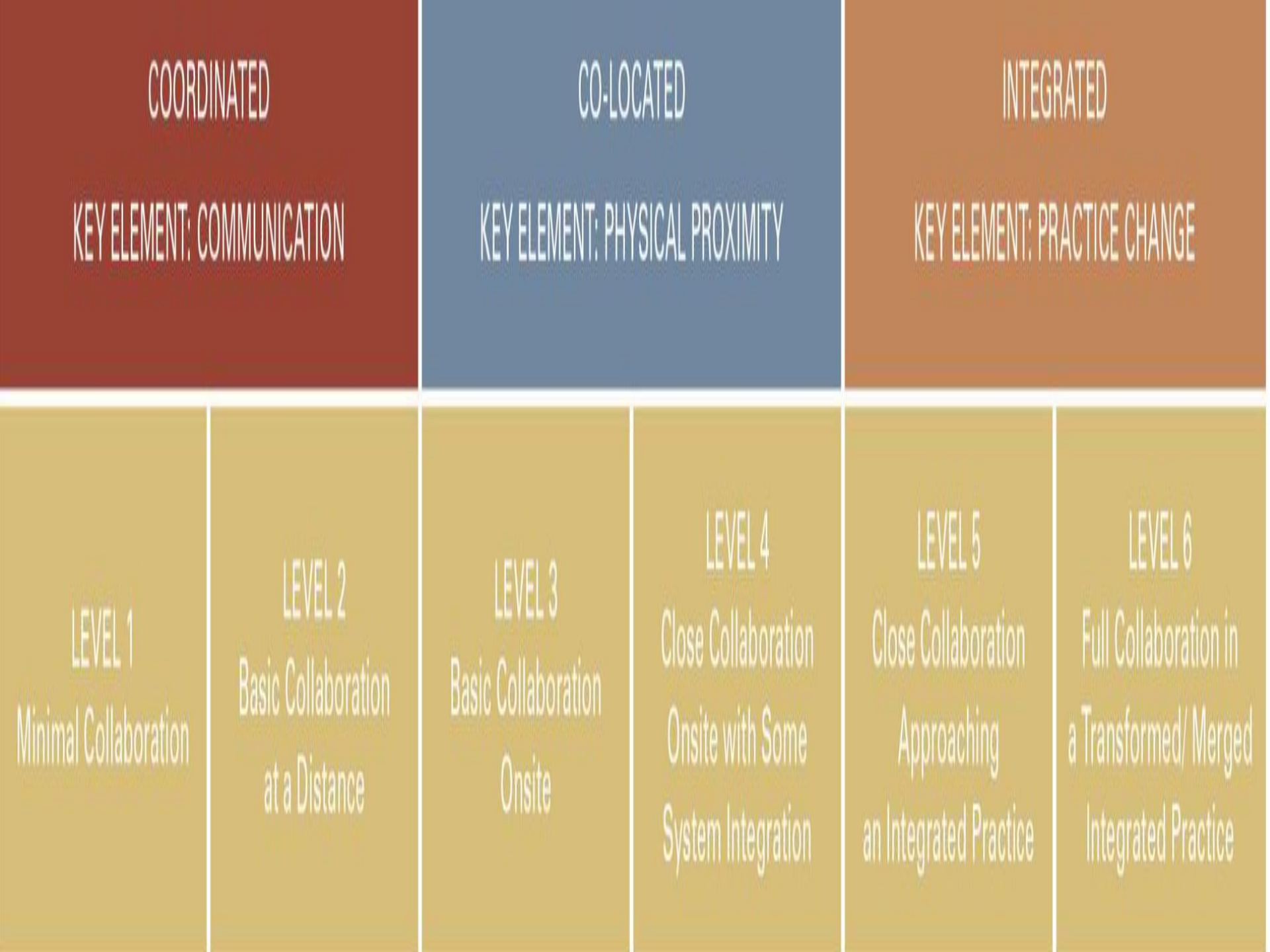
- Start with the major players from all organizations (again)
- Involve the frontline staff in the planning (again)
- Have frequent communication with all levels of staff to assess the success (again)
- Physician buy in is essential to success (and the resident training grant facilitated this!)
- Educate the medical staff about substance use and mental health diagnosis
- Educate the mental health staff about medical diagnosis

# Lessons Learned-Integration

- Be available-even if you aren't busy, being in the medical milieu builds relationships
  - Hot Handoffs
    - Meet the patient with the provider
  - Warm Handoffs
    - Receive the patient after the provider visit
  - Cold Handoffs
    - Paper referral after the patient leaves the clinic

# Lessons Learned-Integration

- Frequent meetings with various disciplines helps to change the culture
- Staff assigned to screening were in place when Attorney General made changes to Opioid prescribing in December 2013
  - SBIRT staff were available to see patients in real time to assist them with additional screening, treatment and referral to treatment


COORDINATED
KEY ELEMENT: COMMUNICATION
CO-LOCATED
KEY ELEMENT: PHYSICAL PROXIMITY
INTEGRATED
KEY ELEMENT: PRACTICE CHANGE
LEVEL 1
Minimal Collaboration
LEVEL 2
Basic Collaboration
at a Distance
LEVEL 3
Basic Collaboration
Onsite
LEVEL 4
Close Collaboration
Onsite with Some
System Integration
LEVEL 5
Close Collaboration
Approaching
an Integrated Practice
LEVEL 6
Full Collaboration in
a Transformed/ Merged
Integrated Practice